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Let's Take a Look at the Aging

By PRESCOTT W. THOMPSON
Director of Retirement and Geriatrics
Menninger Foundation
Topeka, Kansas

The time has come to look at older people more appreciatively, and to look further for ways to help them unlock the potential which is so often there. We are too often inclined to underestimate this potential.

We tend to see older people as sicker or more disabled than they really are. We are inclined to underestimate and to depreciate their potential contribution to their own lives and to the lives of others. Sometimes this potential is locked by discouragement, hopelessness, apathy, or by depression. The older person may appear to be senile when he is not senile; he may, on the contrary, be capable of many good and useful works.

Needs Acceptance

Supposing we wanted to make a list of the emotional and psychological needs of older people. Somebody would tell us that the older person needs to be accepted; another that what he needs is love, or even tender loving care. Others would point up his loneliness and his need to socialize, or his need for good physical health, good nutrition, adequate housing, the chance to keep working at something satisfying.

Of course, there will be a good deal of truth in each of these views. It is true that a good many older people suffer from being lonely; yet some of them seem to *make themselves* lonely. Some could certainly use a large dose of tender loving care, but others may need a firm talking to. Good medical care, good food, and adequate housing are all essentials, but we find that a good many physically healthy and well-taken-care-of people do poorly in the older years.

NOTE — Reprinted with permission from The American Journal of Nursing, Vol. 61, March, 1961.

With all of these various and valid ideas about what older people need, it would be nice to have some guiding principle to underlie what we do with older people. So I am proposing a principle which I believe those of us in the medical and nursing professions will find useful with the older patients whom we see and care for.

The principle consists of two assumptions, representing perhaps opposite sides of the same coin. One assumption is that what a good many of our older patients fear most is helplessness or the possibility of helplessness; the other assumption is that what helps older people most is the realization that they are not helpless, that at least in certain respects they can do something.

Now, if we assume that a good many of our older patients are afraid of helplessness, we must convey to them, first, that we understand how they feel and second, that if they do become helpless, or limited in certain ways, that we are here to help them do those things which they are unable to do for themselves. Considering the other side of the coin, we will do whatever we can to make it possible for the older person to realize that he can do certain things; that at least in certain respects he is not helpless.

I think we need to repeat these themes in a number of ways. In general, the older a person is, the more he may need to be taken care of because the more limited he is in what he can do. But what is so often overlooked is that he also usually has potentialities, and we should help him to find them and to use them. Occasionally, we find a patient who does not want to do anything. In this situation, we should try to understand what it is that stands in his way, and use all of our own intelli-

gence, imagination, initiative and tact, to try to find ways to get him to use his potentialities and skills.

We have a tendency to believe that what the older person needs is a chance to take it easy, to rest, to retire. Certainly, if he needs a rest or relief from certain demands, it is important that we recognize this and try to help him get it. But insofar as he does not really need relief, he should be active in doing something which seems to him worth doing, something which gives him a feeling of mastery, self-respect, and strength of one kind or another.

Early ambulation and exercise are good examples of this principle. The whole point of medical care is to restore function, or at least to help preserve all that we can. A person, young or old, who has a stiff or painful joint, or whose bones are decalcified by long immobilization is, of course, partially disabled, less able to do certain things. If he has the potential to walk, or to use one or more stiff joints, we should do all that we can to help him realize his potential. But more than that, we must help him to preserve or to restore other than purely physical functions. Also, it is what disability means or what doing something means to a person that we most need to understand.

We know that older folk, in general, are increasingly disabled as time goes on. But they may be disabled in different ways. We can roughly categorize three kinds of disability: physical, intellectual, and emotional.

Differentiating Disabilities

Intellectual disability refers primarily to partial loss of such capacities as memory, ability to think clearly and quickly, judgment, and the capacity to orient oneself in time and place. We all know that some older persons are severely disabled in these respects, causing themselves and others serious problems.

Emotional disability refers to such common phenomena as excessive anxiety, fearfulness, irritability, excessive stubbornness, suspicion, or paranoid ideas; also it refers to combativeness, socially undesirable sexual behavior, and the like. All of these emotional difficulties are dis-

abling because they limit contact, force confinement, or otherwise restrict what the patient may do.

A curious thing is likely to happen to us in the face of these disabilities. We are likely to look at disabled older people as if they were suffering from all three kinds of disability. And we tend to assume that nothing can be done with older people who have intellectual or emotional difficulties. Until recent years, before the remarkable development of physical rehabilitation, we even underestimated the possibilities of preventing physical disability, or of restoring physical function.

We tend to lump older people together as if they were old in all respects. We are surprised when an older person thinks clearly or remembers something that has happened recently. A good many people with memory difficulties have been diagnosed as being senile or arteriosclerotic when such was not the case at all. Many with behavior problems have been looked upon as old and therefore as irascible, and the matter quickly dropped as though that settled it, with little real effort made to find out whether the behavior could be improved. The fact is we have often seen disturbed patients become delightful people on the ward.

Older Person is Sensitive

The older person is sensitive to the attitudes of all of us around him. He may have lost his job at 65 just because he was 65, and not because of any important physical, intellectual, or emotional disability. He is told in many little and big ways that he is old, with the implication that he is through, washed-up, useless, unwanted. And society is ready to believe that we are washed-up long before this is necessarily so.

Of course, the older person knows that in some respects he is not the man he was at 25. Particularly from the standpoint of his physique, he has already experienced a steady decline. He may be unable to do things which have meant a great deal to him. Thus his involvement with a job, or sports, or other activities, or spouse and friends, may be increasingly unavailable to him as the years go on.

Strength and Weakness

What do these losses mean? And what gives us the strength to carry on? Some of us find strength through purpose, through doing something which seems to us to be worthwhile. For some of us, it may be our jobs. If we are needed in Room 406, or needed to repair a leaky pipe which threatens to flood a house, or needed to be good parents to our children, or needed to keep union records, we will find strength in being needed, as long as we are up to these various responsibilities. Or the strength may come from identifying ourselves with something larger and stronger than ourselves. We say that we belong to great and noble professions; the union secretary says that he is a member of the United Auto Workers, AFL-CIO; the soldier says he belongs to the "best damn unit in the whole South Pacific." Take away my profession, or my union card, or muster me out of the Army, and for the moment, at least, I will be weaker; take away any hope that I can reinstate myself in some job or group, and I will be still weaker.

Likes to Talk

We also find strength in just talking with people. Sometimes the strength comes from just blowing off, sometimes through realizing that we can be important to someone else, sometimes through the simple realization that we can love, or that others find something good or lovable in us.

But take away a man's spouse, his children, or his friends; take away his job; leave him alone on a park bench; take away some of the things that have given him the courage to believe that he is handsome or desirable like his hair, his teeth, or his muscles; take away those things which make it possible for him to reach out and feel the strength of others, or his own strength; take away his hearing, his vision, his capacity to walk or to climb stairs; then he will feel weak and inadequate indeed.

We doctors and nurses are in a particularly strategic position to help such persons. First, we must evaluate the actual extent of a man's disability. If he is pushed to do things which are beyond his powers, he will feel increasingly inadequate and old.

He will feel that we don't understand, and he may be angry at us for this because it is as important to him that we understand his limitations as it is that we appreciate his remaining capacities. He may become depressed, apathetic, and unnecessarily weak and easily fatigued, just as all of us do on those dark days when we feel that we are good for nothing. He may withdraw, becoming increasingly and unnecessarily unable to handle his own affairs. He may withdraw to the point that he dwells on happier memories from the past and becomes so preoccupied with them that what goes on today simply may not register. His recent memory may thus appear to be poor, and he may quite unnecessarily appear to be "senile."

Sensitivity to Need

So it is true that the first thing that we must do to meet the older person's emotional and psychological needs is to evaluate what his disabilities really are, because to push him to exceed his capacities will only hurt him and make him feel worse. And not to meet those needs which must be met by someone else—not to be sensitive to real weakness, or poor vision, or poor hearing, or slow mental processes, or transitory confusion and disorientation, or pain—will further cause him to withdraw, to give up. Or it may lead him to physically strike out, or to search at night for some friendly and familiar landmark. He may wander through the corridors, or get out of bed when he should stay in it. It will lead him to push the call button often to reassure himself that the nurse is still there, or to cling to the nurse by talking interminably until he can be satisfied that she is interested.

Of course, we must be sensitive to disability and we must make up for it by identifying and compensating for weaknesses. But we must also search for interests, for skills, and make it possible for the patient to do all that he can do.

I am aware that this may be more difficult than it sounds. What does it take, sometimes, to get a patient out of bed the day after surgery? What does it take to get a sedentary man to do prescribed exercises? Some older patients will resist any effort to get them to do anything.

Sometimes the gruff refusal may make us angry. But surely, the art of nursing includes ways and means to get patients interested in being active in one way or another.

Imagination and Initiative

If a nurse finds that two of her patients are interested in cooking, perhaps she can get them together for part of the day to share recipes. Even better, she will get an older woman together with a younger woman; the young wife will learn, and the older woman will feel that she has something to offer. If the interest is in knitting, or in demonstrating card tricks, surely it is part of good nursing to see that materials and patient, or patient and audience are brought together. In some hospitals, we have others who can help us with this job — occupational therapists, group workers, and volunteers — but a good part of the imaginativeness and initiative required to get the patient started will come from the nurse.

In general hospitals I have seen very few patients asked to help out. Why is this so? Is there nothing a patient can do to be helpful to the nursing staff or to the hospital? Is it too much trouble? Or is it reluctance to ask a paying patient to perform a service?

Perhaps it will help to realize that in a psychiatric hospital, if it will help him, the patient is asked to rake leaves, to sand furniture, or even to wash walls and polish floors. The major criterion is whether or not it may help the patient, and not what he is paying for his room. Particularly with the older person, who is fearing the onset of helplessness, doing something useful for the hospital gives a feeling of mastery, which is the opposition of feeling helpless.

I don't want to imply that doing something with the hands is the only form of activity which helps to provide a sense of mastery. The older patient can often profitably share some of his experiences and concepts as a teacher or an elder statesman, and these are always gratifying as well as important roles.

Not long ago I visited a teacher of social work who was in the last stages of a terminal illness. It was possible for her to share thoughts with me about the care of the patient

who is chronically ill and perhaps this helped her feel that there was still something she could do which was important.

She told me that she had become very fond of a highly competent nurse who was on the day shift. She said that she felt that when worse came to worse, this was the person whom she would most like to have with her because she had the feeling that she could trust this nurse to do whatever needed to be done for her.

One day, however, the nurse came in and did many extra things for her which ordinarily were done by one of the aides. The patient wondered about this, but didn't know quite what to make of it until that afternoon when she overheard a farewell party going on at the nurses station just outside of her room. It turned out that it was this very nurse who was leaving that day to start work in another hospital. The nurse had not said one word to the patient about her leaving.

A Branch of Trust

Now I have no doubt but that this particular nurse is a very good nurse. The mistake she made, however, was to underestimate how important the nurse is to her patients. We must let our patients know that we will be on the job and available to them when they need us, at least on certain days and at certain times. When we must leave or go on vacation, we should let the patient know in plenty of time so that he will not be overwhelmed by the breach of trust, or panicked by what he experiences as a desertion at a time of need.

I was so intrigued with some of the things this teacher told me that I asked her if she could write them down. I should have known without asking that she simply did not have the strength to do this. My asking her to do it unnecessarily reminded her of her limitations. This is the kind of thing which leads a patient to feel that the doctor or nurse does not fully understand or appreciate the seriousness of his illness.

There are some patients, of course, who will try to convince us that they are less capable than they really are. We have to be careful with our own feelings about this because most of us are rather allergic to the person

who tells us that he needs more attention than we think he does. The nurse may become engaged in a kind of battle with the patient which leads to unfortunate results on both sides. She becomes angry every time the patient pushes the button, and the patient becomes increasingly angry and frustrated when she doesn't answer it.

Yet, what can we do about those patients who seem to be unnecessarily demanding, spoiled, or selfish?

Demandingness as a Test

It does not necessarily meet the emotional and psychological needs of such a person to continue to give unstintingly of ourselves. However, we must be generous in our attitude toward such a person until we understand better why he makes his demands. Perhaps he is on the verge of being panicked—and some of us become panicked more easily than others—at the thought of illness and the threat of increasing disability. He may be testing us to see whether or not we are capable of being available and of meeting his needs, should he urgently need us. If we can demonstrate that we have the capacity to give, and that we are available and will be available, the intensity of the demandingness will often disappear. We will then — and probably only then—make it possible for the patient to show us his more capable side, and our own feelings will be free enough at that point to permit the kind of imaginativeness we need to help him further demonstrate to himself the extent of his capabilities.

At this point, I think we should reflect upon how it feels to be confused or disoriented. We can sense how frightening this experience is if we recall how we have felt, on awakening from a sound sleep in a strange place. We have momentarily become startled, or even panicky, until we could awaken sufficiently to recognize that the dream we just had was a dream, and to realize precisely where we were among friends.

For the older person, this will sometimes take longer, particularly if there are some senile brain changes, or if it takes a while to restore brain circulation. It is even worse when there is some visual or auditory deficit.

There is much we can do to pre-

vent or at least to decrease the discomfort of such experiences. A night light will help to speed up the process of orientation, as will speaking quietly to the patient, reminding him where he is and who you are. When an old gentleman wanders out into the hall in his nightshirt at 2:00 a.m., the nurse can help to orient him by quietly introducing herself as the night nurse, and asking him if he would like to have some help in finding the bathroom. Gently taking his arm, she can reassure him that he is in good hands, and that she will help him make up for his frightening confusion. She may need also to offer a few more soothing words to the effect that it is 2:00 a.m., that this is such and such a hospital, that he is in the corridor, that his room number is 206, and that she knows it must be difficult or frightening to wake up in a strange place.

Sometimes it is helpful to offer the confused patient a small snack in the well-lighted diet kitchen. The use of words which are familiar to him, such as sandwich, custard, ice cream, milk, hot chocolate, or refrigerator, may further help him to get his bearings. Feeding says many things and is one way to convince the patient that malevolent forces do not lurk in every corner, as some old people are likely to believe. Offering food is one way to demonstrate that you are there to help.

There are, of course, those patients who insist upon doing more than may appear to be good for them. Older persons for years have resisted coming to the hospital, or resisted being kept in bed. It took us all a long time to realize that in certain ways they were right, the immobilization or bed rest may in themselves produce further disability, or even lead to death. The older patient seems to know this better than we. But of course he is also saying that his family, his friends his interests, and his activities are all of crucial importance to him. It isn't just that he wants to die with his boots on. He tells us that he *has* to die with his boots on, or take the risk of dying much sooner, either physically, intellectually, or emotionally.

Liberty of Spirit

There are times when a man senses that physical death is preferable to

emotional or spiritual death. Psychological, emotional, spiritual pain is always harder to bear than physical pain. This is one of the reasons that some older people will want to stay on their feet. In one sense, it is something we want to encourage. A strong spirit will help to keep a weak body stronger.

If excessive physical activity must be avoided, however, one solution is for us to help provide some other activity. The precise activity will, of course, depend upon the individual patient. Sometimes it will be television, sometimes a chat with someone else, sometimes a book, sometimes writing letters, or exercising in bed or playing cards, modeling clay, fingerpainting, or the like. For patients who are with us for some time, these facilities should be available. An activities room for those who can be in wheel chairs, or even in a raised-up bed, will stimulate the interest of some patients; just being with others who are occupied will reduce the drive toward inappropriate and unwise activity. And, older people who are meeting each other's needs will make fewer demands on the personnel.

The time has come to recognize the value of the contribution which the older person can make if we will only let him by showing our appreciation of that value. The older person will respond to this attitude, as long as we do not push him. And so long as we know how difficult it is

for him, he will meet us more than half way.

Adopted from a paper presented at the Institute on Nursing of the Senior Citizen, University of Kansas Medical Center, Feb., 16, 1960.

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COVER PICTURE:

The hours fly by as swiftly as a weaver's shuttle since the occupational therapy assistant taught Clara Rietzke to weave. Mrs. Rietzke is a patient at the Wheaton Nursing Home in Montgomery County, Maryland. Approving her work are Mr. Jerome Maibaum, a resident at the nursing home, and Mrs. Rietzke's instructor, Mrs. Viette Lawton. Photo from Georgia Jameson, Montgomery County T.B. & Heart Ass'n, Kensington, Me. Photo by Leet-Melbrook, Inc.

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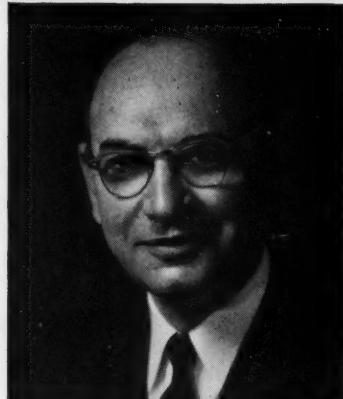
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Aspects of Rehabilitation In Nursing Home

By JOSEPH KLEIMAN, Director
Morristown Rehabilitation Center, Inc.
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Anyone conversant with the current literature in the health field is aware of the many changes that are taking place in the planning and operation of nursing homes. Administrators of nursing homes are becoming conscious of their status in the community and are in the process of defining the levels of care to be provided in their facilities. They are beginning to view their services not only as a place for "custodial" care as such, or as an institution for generalized nursing care. Instead there is a growing awareness of suiting the services to the needs of the individual patients. It is in this context that rehabilitation can be considered in a nursing home facility.

Having said this much we must then set down several qualifications. Firstly, the nursing home has not as yet found its niche. Very little can be generalized about nursing homes. Its very location, auspices and ownership is under review. Secondly, one finds great variations from state to state, from town to town and from uptown to downtown, or on the same street. There are islands of anachronistic poor homes and islands of services of high standards. It will take some time for the former to vanish from the scene and for the latter to become the standard of operation.

What is Rehabilitation

The whole program of rehabilitation has become a shibboleth as so many want to espouse it so often without having a clear concept of its philosophy, method, or application. Most everyone agrees on its purpose which is to restore the patient to his previous condition. Even this is only a general statement with the result that it may become a cliche and little more.

Nevertheless, rehabilitation should

be carefully considered in future planning of nursing homes because its practices, when properly understood and performed, are becoming part of our scene and operation.

To begin with, rehabilitation is generally defined as restoring the patient to his fullest physical, mental and social capacities. Such a definition implies no mythical gauge or norm against which the patient is measured. The yardstick is always the abilities — or limitation — of the patient under treatment. Within such limits, the goal is clear.

Therapy Goals

The goals of therapy differ from patient to patient. For one it may be full earning capacity, for another it may be "self care," and for a third it may be partial assistance in activities of daily living. In each case, the therapist is striving for the maximum. The goals of rehabilitation need never be far fetched but clear and specific. The process or method is never simple or necessarily easy.¹

It is imperative that distinctions be made at this point between a program of rehabilitation therapy and an orientation to rehabilitation as a philosophy in the care of patients. The latter offers acceptable concepts in the treatment of any patient, and need not involve special techniques in its application. It expresses itself in the care and concern of the patient as an individual.²

The physician and the nurses as well as all members of the team see the patient not so much in order to deal with his disease or "condition" but to help Mr. John Jones to get back on his feet. In order to reach this goal other procedures in addition to the doctor's prescription

Mr. Joseph Kleiman has a B.S. degree from City College of New York, N. Y.; an M.A. degree in psychology from Teachers College, Columbia University of the same city; and an M.S.S. degree from the Graduate School of Jewish Social Work which is now affiliated with the New York School of Social Work, Columbia University. He is presently director of the Morristown Rehabilitation Center, Inc., Morristown, N. J. Previously he served as director of the Riverside Home for Aged, New York, N. Y., and the B'nai Brith Home and Hospital, Memphis, Tennessee.

may be necessary.³ For one thing his reaction to being a patient requires understanding. This opens up a whole panorama of possibilities requiring professional skills in personality adjustment under stress, family relationships, motivation toward success or failure, group reactions, and a host of other pertinent questions. When the patient is viewed in such terms, any planned program on a group basis should include more than care for his day to day needs.

Recreational and Occupational Therapy

The need of some program of recreational therapy and occupational therapy, to take one example, takes on a meaning beyond mere keeping patients busy or doing something for the patients. Such programs and others like it become important as tools or opportunities to do something with the patient in order to speed his recovery.

The National Recreation Association has entered the nursing home field during the last five years and proven in actual performance in many localities of this country the great rewards that such a program can bring to patients. It has proven

that such a group program need not be expensive beyond the reach of the average nursing home.^{4,5}

Similarly occupational therapy, often known as arts and crafts, has become an integral part of the program of progressive homes. The help that it provides to the patient is often beyond measure, and has been reported in detail. It should be stated that the mechanics of the program is only incidental to its use in the patient's process of recovery, which is so often affected by his morale, attitudes, and motivation to get well.

The program outlined above can be instituted in any nursing home where the administrator approaches his task professionally and with a deep interest in his patients as people. Much understanding and a dash of imagination can go a long way.

However, when we are dealing with a rehabilitation program for physical restoration, it necessarily is a specialized service where adequate staff and equipment are included. This refers only to nursing homes specializing in the care of stroke, fracture, arthritic, Parkinson and multiple sclerosis patients, to name a few. This program is usually under the supervision or with the consultation of an orthopedist or physiatrist.

Additional services for the patient are required and when offered, involve additional costs in line with the individual program outlined for the patient.⁶

Experience of one Center

The Morristown Rehabilitation Center has been in operation on these principles for over six years, and has been able to return hundreds of patients to their homes after a full period of treatment. The cost of the treatment to the patient can be computed to be much less than the possible cost in nursing homes without rehabilitation because their stay in such a home would have to be quite indefinite. These patients and their families invested in an intensive therapy program in order to become independent of continuous care. It is high time to do away with the old concept of the nursing home as a "terminal station."

I do not advocate that nursing homes employ registered physical therapists, occupational therapist, or equip themselves with parallel bars and other modalities of physical therapy treatments. This applies only to the specialized home that offers physical rehabilitation as part of its program. But the philosophy of care and some of its basic techniques are applicable to all nursing homes. Reports of pilot projects are available and should be incorporated in our program wherever possible.⁷

Dr. Malcolm J. Ford in referring to rehabilitation techniques states: "The most hopeful aspect of this recent development is that many of the techniques are simple and can be applied with inexpensive materials by properly trained nursing aides and orderlies, under supervision."⁸

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- ⁸ Malcolm J. Ford, M.D., "Today's Problems and Needs in the Nursing Home Field," *Nursing Homes*, June, 1958.
- ⁹ Jerome Kaplan, "Perspectives in Nursing Home Care," *Geriatrics*, Oct., 1959.
- ¹⁰ "Nursing Home Goals," *Public Health Reports*, *Public Health Service Publications*, No. 732.

No doubt every administrator will concede the importance of economy in nursing care. But economy cannot become paramount to the extent of narrowly limiting our services and possibly taking the heart out of the patient-care to which we are dedicated.

The popular attitude of oldsters and their families to nursing homes has not been too good. We have had to live down the negative generaliza-

tion so frequently made against us because of widespread low standards of care in many homes a decade ago. We still have to contend with current attitudes expressed or tacitly accepted by some professional groups in related fields. Some physicians, social workers, administrators of homes for the aged, who may be in the minority, still persist in considering the admission of a patient to a nursing home as a step downward in his care.

Perspectives for the Future

In our attempts to overcome such lingering misconceptions about our services, facilities, and goals for patient care, we can again be trapped when the economy of our operation is overstressed while witnessing a soft pedalling of our program and philosophy.

All other considerations aside, the progressive nursing home must measure up to the challenge that each patient as an individual presents.

Our perspectives must be contemporary to our times. None of us can operate in isolation and with a l'essaiz faire attitude. The needs of the older segment of the population are growing in complexity. Our services must match the needs in being flexible and fluid to suit the demand. The average nursing home should provide basic services for the chronically ill and convalescent. These should be comprehensive and garnished liberally with a positive philosophy of good care.

At the same time, those patients requiring specialized care due to neurological malfunction, mental difficulties, or orthopedic problems should be treated separately where such services are available on an adequate level. With such differentiation, the public will recognize that our standards of care are commensurate with the diagnosis and needs of the patient. The families of our patients will in this way be our best ambassadors of good will.

The American Nursing Home Association has been in the forefront in establishing a professional code of ethics for administrators and owners. More recently attempts are being made at a program of "accreditation" of nursing homes, based on the stand-

ards of care that nursing homes give to their patients. These are proper activities in self-regulation that the nursing home field is instituting. It is the process of transformation from a business to a profession, despite the fact that most homes are proprietary.¹⁸

When such splendid efforts are made in our emergence on the national scene, we cannot jeopardize it by entertaining limitation in our standards of care. Our constant struggle must be to bring up the laggards in our midst to acceptable high standards. We can do so by widening our horizon and emphasizing the basic virtues of glorifying our patient whom we serve. He should represent to us the image of God in which he was created. Nothing less.

Life expectancy near 120 predicted by year 2000

Life expectancy may approach 120 years in America by the end of this century, according to the Journal of the American Medical Association.

A steady upgrading of longevity in the West may reach the reputed longevity of certain peoples in the East, an editorial in the February A.M.A. Journal said. More than 20 Civil War veterans passed the century mark with the oldest living to be 117, the Journal reported.

There is evidence that men in Hunza Land, a remote and mountainous region of northern Pakistan, live to be 120 or even 140, the editorial stated. Although not documented, it said, such ages are believed to be within the limits of possibility.

"If scientific advances continue to be productive, and there is little doubt but that this will be factual — with eradication of infection, prevention of cancer, and inhibition of progression of the degenerative diseases — life expectancy in America should approach that of the fabled Hunzukuts by the end of this century and equal that of the Himalayan dwellers in the 21st century," the Journal concluded, adding that "The problems posed by such a probability merit careful study."

TENTATIVE CONVENTION SCHEDULE

AMERICAN NURSING HOME ASSOCIATION

Pick Carter Hotel, Cleveland, Ohio

October 2-6, 1961

Sun., Oct. 1

2:00 p.m. Executive Board meeting

Mon., Oct. 2

8:00-9:30 a.m. Regional meetings — Briefing on agenda.
9:45-12 a.m. Governing Council meeting
1:30-4 p.m. Governing Council meeting
4:00-6 p.m. Formal Opening of Exhibits
7:30 p.m. Reception — Early Birds Flock Together

Tues., Oct. 3

8:00-9:45 a.m. Regional Meetings
10:11:30 a.m. General Session — Key Note Speech
12:15-2 p.m. Luncheon—Fashion Show — Speaker
2:15-4:30 p.m. Business Session
4:30-6 p.m. Exhibits
6:00-? p.m. Exhibitors Night — Exhibitors free to schedule Social Functions — No official sessions of convention to be held

Wed., Oct. 4

7:00-9 a.m. Executive Secretaries & State Presidents' Breakfast
9:15-11:15 a.m. General Session — 3 Speakers
11:15 a.m.-12:30 p.m. Exhibits
12:30-2 p.m. Luncheon — Fashion Show — Speaker
2:00-3 p.m. Exhibits
3:00-5 p.m. Trading Post
5:00-7 p.m. Exhibits

Thurs., October 5

9:15-10:15 a.m. Trading Post Reports
10:15-11:15 a.m. Business Session

Thurs., October 5

11:15 a.m.-2:00 p.m. Exhibits
2:00-4:00 p.m. Election of Officers
7:30 p.m. Banquet

Fri., Oct. 6

9:00 a.m.-12:00 noon Governing Council meeting

All Governing Council and Executive Board meetings are open to all members.

WRITE FOR FREE BOOKLET on:

LEGAL LIABILITY in the Nursing Home

WM. K. O'CONNOR & CO.

53 West Jackson Blvd.

Harrison 7-1721

Chicago 4, Illinois



ALFRED S. ERCOLANO

There have been very few times in my life when I have been at a loss for words. This is one of those times. I wish there were some way for me to say thank you for naming me as your Executive Director, without having it sound trite. All I can say is that I hope I can justify your confidence in my ability in the years to come.

Again, let me say . . . THANK YOU.

Sincerely,

alfred s. ercolano

Executive Director

Nursing Home Patient

Rehabilitation Study

A continuation grant of \$55,000 was recently received by the department of Physical Medicine and Rehabilitation and of Preventive Medicine, to complete the treatment objectives of a study on Rehabilitation Potential of Nursing Home Population and to analyze and interpret the statistical and clinical results of the study. Previous grants received for the initiation and conduct of the study totaled more than \$300,000, beginning in February, 1958, and ending October, 1960. The recently approved grant of \$55,000 represents a termination award.

The Nursing Home Patient Rehabilitation Study, which is conducted by the departments of Physical Medicine and Rehabilitation and of Preventive Medicine of New York Medical College, is sponsored additionally by the Department of Health, of Hospitals, and of Welfare of the City of New York. In addition, it represents a cooperative undertaking of two medical schools, official New York City and New York State agencies, and fifteen proprietary nursing homes located in New York City.

The major purpose of the study is to determine the potential for re-

habilitation of aged, public assistance recipients who are proprietary nursing home residents in New York City. More than 400 patients were chosen for study, and treatment efforts involved a total of approximately 200 patients. During the termination phase of the project, which is made possible by the award of this continuation grant, the results of these efforts are to be analyzed.

It is also felt that additional data, not originally anticipated when the study was initiated, will be forthcoming which will be of importance in providing more adequate services to nursing home patients and better care and rehabilitation for all aging patients. New information on the dynamics of the rehabilitation process is anticipated — which persons respond better, which techniques and approaches are more likely to be successful, what nursing home conditions impede or advance the patient's course. Steps toward measuring the quality of the care provided are being made.

Principal investigators for this project are Dr. Jerome S. Tobis, Professor and Chairman, department of

Physical Medicine and Rehabilitation, and Dr. Joñas N. Muller, Professor and Chairman, department of Preventive Medicine, New York Medical College. Dr. Howard R. Kelman, Assistant Professor, departments of Physical Medicine and Rehabilitation and of Preventive Medicine, is project administrator. Principal co-investigators are: Dr. Bruce Grynbaum, Director, Physical Medicine and Rehabilitation, New York City Department of Hospitals; Dr. George James, Deputy Commissioner of Health, New York City Department of Health; Dr. Arthur Abramson, Professor and Chairman, Rehabilitation Medicine, Albert Einstein College of Medicine, and Dr. Morton Hoberman, Chief Rehabilitation Services and Research, New York State Rehabilitation Hospital.

The project has been supported by grants from the National Institutes of Health, the Bureau of Chronic Disease — New York State Department of Health, and the Benjamin Rosenthal Foundation.

Reprinted from New York Medical College "News and Notes," January, 1961.



NOTE: From the Convention Program of the Wyoming Association of Licensed Nursing Homes.

By CALISTA B. FULKERSON
Medical Facilities Consultant,
Department of Public Health,
Cheyenne, Wyoming

The Wyoming State Department of Public Health Medical Facilities Division has just completed its 1961 and 1962 inspection of Nursing Homes and related facilities in Wyoming.

The picture of the conditions found during this inspection is gratifying and reflects definite improvement in over all care of the aged in Wyoming licensed facilities. A continuing interest in establishing safety measures within the physical facility was noted as was the warm personal interest shown in the total well being of the individual guest. It was also gratifying to see that much progress is being made in the mental and physical rehabilitation of our aged.

It would seem that with the phenomenal growth of the Wyoming Association of Licensed Nursing Homes during the past four years and the active participation of this Association at the national level a new horizon has been sighted.

The President and the Board of the Wyoming Association of the Licensed Nursing Homes is to be complimented upon: 1. The fine leadership they have given during

this past year; 2. Their untiring efforts to stimulate in the heart of each operator a higher goal for improvement in patient care; 3. Bringing the great State of Wyoming into the National picture by representation on the Governing Council of the American Nursing Home Association. It has been a privilege for the Wyoming State Department of Public Health Division of Medical Facilities to work with the Wyoming Association of Nursing Homes, and we sincerely hope this may be a long continuing relationship.

Van Dyk Nursing Home Ground Breaking

The Van Dyk Nursing Home has celebrated its ground breaking ceremonies for a new two-story 80 bed nursing home at 304 South Van Dien Avenue in Ridgewood, N. J. Contractors for the building, Thompson Brinkworth, Inc., of New York City plan to complete the new nursing home in one year. Estimated cost of the project is \$850,000. Present at the ceremonies were Mrs. Helen Holt, head of the Federal Housing Administration Nursing Home Division; Mrs. Martha Lough Trainor, Assistant Chief, Bureau of Community Institutions, Department of Institutions and Agencies; Mrs. Clarice McGarry, Valley Hospital administrator; Commissioner Homer G. MacVean and former Ridgewood Mayor, Robert L. Olson. Mrs. Holt said the home is the first in New

Jersey to be insured under F.H.A. which will insure 75% of the mortgage. The building will be completely air-conditioned and will have an inner sprinkler system.

Northeastern Receives \$500 Nursing Home Grant

Northeastern University has received a \$500 grant from the Massachusetts Federation of Nursing Homes (M.F.N.H.) to conduct an evaluation and study of Northeastern's pioneering seminars for nursing home administrators, it was announced recently.

"This grant is particularly significant because the nursing home is occupying a position of ever-increasing importance in our medical and social communities," Francis L. Hurwitz, 14 Egmont Street, Brookline, N. U. Director of Special Programs, said.

"The rapid growth of the nursing home in our increasingly complex society requires careful analysis of its current status; in fact its future welfare demands that the administrator have knowledge and understanding which could not have been imagined a short decade ago," he added.

Northeastern became the first institution of higher learning to offer college-level training for nursing home administrators and owners last fall, when it held a four-day residential workshop. Currently 70 persons are enrolled in 10-week workshops that meet once a week for six hours. The programs are offered in co-operation with the M.F.N.H.

"We would hope that Northeastern's experience and the evaluation of this experience would lead to an extension of education and training facilities in this most important area of nursing home care for the aged," Edward F. Connelly, executive director and general counsel for the M.F.N.H., said in informing the University of the grant.

A car dealer who was having trouble collecting installments, wrote a customer: "What would your neighbors think if I repossessed the car?"

Two weeks later he received this reply: "All the neighbors think it would be a lousy trick."



Sample Menus for 30 Days

On December 30, 1960 (as mentioned in this column at that time) a U.S.D.A. order relaxed controls on moisture content of Federally inspected uncooked smoked hams. Since the relaxation of the controls, so many objections have been raised that public hearings have been scheduled in seven cities to give interested persons a chance to express their views. In addition to listening to anyone who wishes to testify at the hearings, the Department of Agriculture has asked any interested person to present his views in writing.

Written statements about cured pork may be sent to the Administrator, Agricultural Research Service, U. S. Department of Agriculture, Washington, D.C. This is the second chance the public has had to express views on this regulation. Before the December 30 order, the same invitation was issued by the Department, though it was apparently not well publicized.

How It's Done

Modern quick curing of pork starts with pumping of a pickling solution into the fresh cuts. From 1950 to December 1960, the U.S.D.A. allowed adding only as much moisture as would evaporate during the smoking process. This affected only hams processed in Federally inspected plants or those being shipped across state lines. The 10 per cent added moisture allowance affects only uncooked smoked hams, pork shoulder picnics and pork shoulder butts cured in U.S.D.A. inspected plants or those traveling in interstate commerce. It places no such limitation on similar products processed in plants not Federally inspected whose hams are to be sold within the state. However, some non-regulated processors hold down the moisture content of their products because of their own high standards. Also, some U.S.D.A. regulated processors are still not adding moisture to increase ham weight to the allowed 10 per cent.

Pay for Water

Consumers cannot tell by looking at a ham how much moisture has been added. Phosphates added to pickling brine make it possible to increase ham weight to 130 per cent of its green weight, without the ham's looking wet. This much added water would yield a 13 pound cured ham from a 10 pound fresh ham, but it takes unusual processing skill to get this result. The 10 per cent added moisture now allowed by U.S.D.A. would yield an 11 pound ham from a 10 pound fresh ham.

If you'd like to return to the old U.S.D.A. regulations, write your views to the Agricultural Research Administrator. Remember though, that U.S.D.A. does not control all of our processing plants, but all hams sold in this state do come under the supervision of the State Board of Health. The Health Department has already expressed an intention of tightening ham regulations and labeling, but consumer comments would be welcomed.

Fresh Vegetables

Sunny weather suggests fresh salads and cooked green vegetables. Lettuce is plentiful and cheaper than usual again, and there's plenty of low cost carrots, green onions and radishes. You'll see specials on our usual moderate cost greens as well as more expensive ones. Artichokes are about half their usual high price because supply is larger. This is the peak supply time for asparagus, so watch for good buys on fresh tender spears.

Sample Menus . . .

(For Those Not Requiring Special Diet)

Ask a person about his nursing home and he will likely tell you about the food. Food that tastes good goes a long way toward keeping nursing home residents happy. Food that meets the daily nutritional needs of the residents goes even further toward keeping them well.

For some, good planning and preparation of the normal diet is enough; others need special diets; those who can take normal diets but have trouble chewing need to have some foods ground or chopped.

A diet that satisfies the wants of the people in your home might not satisfy their needs. Check yourself each day to see that you are providing for each patient, (1) at least a pint of milk as a beverage or in cream soups, custards, or creamed foods; (2) two

or more servings (two or three ounce size) of high quality protein; (3) four or more half-cup servings of vegetables or fruits, (include in this group a good source of Vitamin C each day and a green or yellow vegetable every other day); (4) four or more servings of enriched bread or cereal. Other foods should be included as needed to complete meals and provide needed food energy. Except in specific instances, no bread or beverage (other than milk) has been listed in menus below:

* See Enclosed Recipes For:

400° Baked Chicken

Baked Chicken Supreme

Congealed Strawberry Pie with Whipped Evaporated Milk Topping

Breakfast

4

Orange Juice
Wheat Chex with Milk
Crisp Bacon
Toasted Sweet Rolls

Lunch or supper

Beef Roast with Gravy
Oven Roasted Potatoes
Buttered Carrot Slices with Brown Sugar Whole Wheat Bread
Berry Cobbler — Coffee Cream

Dinner

Creamy Potato Soup
Deviled Eggs
Tossed Green Salad
Pumpkin Dream Whip Pie
Milk

5

Chilled Grapefruit Sections
Hot Oatmeal with Milk
Link Sausages
Bran Muffins
Apple Jelly

Chicken Chow Mein on Rice
Buttered Summer Squash
Chef's Salad with 1000 Island Dressing
Herb Buttered French Bread
Banana Custard

Toasted Deviled Ham Sandwiches
Steamed Buttered Okra
Cherry Gelatin-Cottage Cheese Salad
Baked Apple with Cream
Milk

6

Blended Orange and Pineapple Juice
Cornflakes with Milk
Grilled Ham Slices
Cinnamon Toast

Breaded Veal Steaks
Poppyseed Noodles
Tomato and Eggplant Casserole
Strawberry Shortcake with Whipped Topping

Vegetable Soup
Corn Sticks
Pineapple-Grated Cheese Salad
Topped with Maraschino Cherry
Nutmeg Cake with Broiled Coconut Frosting
Milk

Breakfast

11

Chilled Grapefruit sections
Raisin Bran — Milk
Soft Scrambled Eggs
Buttered Toast — Strawberry Preserves

Lunch or supper

Roast Leg of Lamb — Mint Sauce
Parsleyed Potatoes
Glazed Carrots
Fruit Gelatin Mold
Lime Sherbet — Vanilla Cookies

Dinner

Chicken-Corn Casserole
Buttered Green Baby Limas
Cottage Cheese and Pear Salad
Milk — Peanut Butter Cookies

12

Chilled Orange Cubes
Egg Omelet
Crisp Bacon
Bran Muffins — Butter
Milk

Chicken a la King in Toast Cups
Baked Beans
Sliced Tomatoes
Hot Apple Pie with Toasted Cheese Wedge
Mixed Fruit Punch

Shepherd's Pie
Buttered Brussels Sprouts
Tossed Green Salad
Boston Cream Pie
Milk

13

Broiled Half Grapefruit with Honey
Soft Scrambled Eggs
Crisp Bacon
Buttered Toast
Milk

Breaded Hamburger Steaks with Cream Gravy
Mashed Potatoes
Turnips with Tops
Peach Cobbler

Cream of Tomato Soup
Tuna Salad Sandwiches
Congealed Pineapple — Shredded Carrot Salad
Spice Cake Squares
Milk

Breakfast

18

Pineapple and Grapefruit Juice
Wheat Chex with Milk
Crisp Bacon
Poached Eggs
Toast

Lunch or supper

Orange Glazed Ham
Scalloped Potatoes with Chives
Broccoli — Lemon Butter Sauce
Chilled Peach Halves — Sugar Cookies

Dinner

Creamed Dried Beef on Toast
Crowder Peas
Shredded Carrot and Pineapple Salad
Cinnamon-Raisin Rolls
Milk

19

Chilled Grapefruit Sections
Cream of Wheat Cooked in Milk
Soft-Boiled Egg
Toasted English Muffins — Butter

Spiced Beef Tongue
Potatoes Cooked in Jackets
Green Beans with Mushrooms
Bran Muffins
Pumpkin Dream Pie

Tuna with Noodles
Buttered Mixed Vegetables
Peach with Cottage Cheese Salad
Cherry Cobbler

20

Blended Orange and Peach Juice
Cornflakes with Milk
Soft Scrambled Eggs
Buttered Whole Wheat Toast — Honey

400° Oven Baked Chicken*
Cream Gravy
Fluffy Steamed Rice
Glazed Whole Carrots
Harvard Beets
Congealed Strawberry Pie*
Whipped Evaporated Milk Topping

Cheeseburgers
Hot Potato Pattie
Buttered Spinach with Grated Hard Cooked Eggs
Spiced Prunes — Cookies Milk

Breakfast

25

Orange Juice
Branflakes with Milk
Poached Egg
Buttered Toast — Apple Jelly

Lunch or supper

Sliced Roast Turkey
Giblet Gravy
Mashed Potatoes
Asparagus Tips in Cheese Sauce
Cranberry Jelly
Hot Rolls
Angel Cake with Strawberries and Ice Cream

Dinner

Turkey Vegetable Soup
Saltines
Glazed Carrots
Seasoned Steamed Chopped Kale
Frosted Cup Cake
Milk

26

Blended Citrus Juice
Special K with Milk
Soft Scrambled Egg
Buttered Cinnamon Toast

Tuna-Cheese Puff
Potatoes and Peas in Cream Sauce
French Style Green Beans
Apple Cobbler a la Mode

Eggs a la King on Whole Wheat Toast
Buttered Mixed Vegetables
Beef Relish
Sliced Peaches with Whipped Topping
Milk

27

Chilled Grapefruit Sections
Sugar Frosted Flakes with Milk
Grilled Ham Slice
Buttered Popovers — Apple Butter

Steamed Sliced Corned Beef
Cottage Fried Potatoes
Buttered Steamed Cabbage
Pear and Cream Cheese Salad
Fresh Pineapple Upside-Down Cake

Chicken Pot Pie
Stuffed Baked Potato Halves
Steamed Broccoli with Lemon Butter Sauce
Whole Wheat Bread
Brownies — Milk

for a Month

<p>1</p> <p>Breakfast</p> <p>Stewed prunes Special K — Milk Crisp Bacon Buttered Toast</p> <p>Lunch or supper</p> <p>Pot Roast with Vegetables Rice in Brown Gravy Broccoli with Parmesan Cheese Buttered French Bread Fresh Strawberries with Whipped Evaporated Milk Topping*</p> <p>Dinner</p> <p>Hot Vegetable Soup Cheese — Crackers Citrus Fruit Salad Applesauce Cake Milk</p>	<p>2</p> <p>Blended Citrus Fruit Juices Hot Protein Plus Cereal Bacon Poached Eggs Buttered Whole Wheat Toast Milk</p> <p>Macaroni and Cheese Buttered Brussels Sprouts Escaloped Tomatoes Corn Sticks Vanilla Ice Cream Brownies</p> <p>Creamed Tuna on Toast Buttered Asparagus Fruited Harvard Beets Yellow Cake with Chocolate Frosting Milk</p>	<p>3</p> <p>Braised Beef Liver Buttered Green Peas Steamed Cauliflower with Grated Cheese Beet Relish Hot Biscuits Pineapple-Vanilla Wafer Pudding</p> <p>Jellied Ham Loaf Pimiento Cheese — Crackers Assorted Fruits Head Lettuce with French Dressing Fudge Sundae Milk</p>
<p>7</p> <p>Rice Krispies with Milk and Strawberries French Toast — Butter Maple Syrup</p> <p>Ham Loaf with Sauted Pineapple Sweet Potato Casserole Buttered Green Beans Beet Relish Cake Square — Lemon Topping</p> <p>Clam Chowder Cream Cheese on Brown Bread Molded Shredded Carrot and Raisin Salad French Dressing Strawberry Shortcake Milk</p>	<p>8</p> <p>Grapefruit Juice Hot Oatmeal with Milk Poached Egg Buttered Toast</p> <p>Rich Brown Stew with Vegetables Steamed Red Cabbage with Toasted Almond Slivers Waldorf Salad Corn Sticks Strawberry Chiffon Pie</p> <p>Shirred Eggs in Bacon Rings Broccoli with Cheese Sauce Pear Half filled with Peanut Butter & Honey Ball Toasted Whole Wheat Bread Oatmeal Cookies Hot Chocolate</p>	<p>9</p> <p>Stewed Prunes Cream of Rice Cooked in Milk Crisp Bacon Buttered Cinnamon Toast with Grape Jelly</p> <p>Salmon Croquettes — Cream Gravy Dry Steamed Rice Buttered Spinach Brown and Serve Rolls Orange and Honey Ambrosia Gingersnaps — Fruit Punch</p> <p>Cheese-Tomato Rarebit on Toast Buttered Potato Cubes Turnips with Tops Peach Tapioca Milk</p>
<p>10</p> <p>Blended Fruit Juices Apple Pancakes Crisp Bacon Maple Syrup — Honey</p> <p>Beef Ragout with Vegetables Baked Corn Casserole Stewed Dried Apples (No Spice) Banana Cake</p> <p>Cream of Tomato Soup Deviled Eggs Hot Buttered Crackers Fresh Fruit Compote Vanilla Cookies Milk</p>		
<p>14</p> <p>Orange Juice Hot Ralston in Milk Canadian Bacon Buttered Raisin Toast</p> <p>Ham Slices with Raisin Sauce Buttered Noodles Sliced Tomato Salad — Italian Dressing Hot Rolls Lemon Meringue Pie</p> <p>Creamed Dried Beef on Mashed Baked Potatoes Cranberry Relish Tossed Green Salad Buttered French Bread Ice Cream with Berry Sauce</p>	<p>15</p> <p>Cornflakes — Fresh Strawberries with Milk Link Sausages Hot Biscuits — Butter Cherry Preserves</p> <p>Broiled Beef Liver and Bacon Baked Potatoes with Butter Buttered Yellow Squash Molded Fruit Salad Whole Wheat Bread Gingerbread with Chocolate Sauce</p> <p>Macaroni with Cheese French Cut Green Beans Mixed Fresh Fruit Salad Peach Cobbler with Coffee Cream Milk</p>	<p>16</p> <p>Blended Fruit Juices Hot Oatmeal with Raisins — Milk Shirred Eggs in Bacon Rings Whole Wheat Toast</p> <p>Baked Ocean Perch — Tarter Sauce Oven Baked Potato Cubes Buttered Brussels Sprouts Corn Sticks Citrus Fruit and Endive Salad Rhubarb Betty</p> <p>Whole Meal Sandwich (Cheese, Sandwich Meat, Lettuce, and Relish) Buttered Broccoli Congealed Fruit Cocktail Salad Lemon Icebox Pie</p>
<p>17</p> <p>Orange Juice Crisp Bacon French Toast Maple Syrup</p> <p>Oven Braised Pork Chops Herb Rice Buttered Chopped Spinach Lettuce — Roquefort Dressing Cheese Biscuits — Apple Jelly Chocolate Cake a la Mode</p> <p>Ham a la King on Biscuits Buttered Whole Okra Pineapple and Shredded Cheese Salad Milk Shake — Refrigerator Cookies</p>		
<p>21</p> <p>Corn Flakes with Sliced Bananas and Milk Ham Omelet Hot Muffins — Butter — Peach Preserves</p> <p>Meat Loaf with Tomato Sauce Escalloped Potatoes Mixed Greens Pineapple-Cottage Cheese Salad Ice Cream — Butterscotch Sauce</p> <p>Cheese Souffle Brussels Sprouts with Lemon-Butter Sauce Sliced Tomatoes Bran Muffins Orange Custard Spiced Milk Drink</p>	<p>22</p> <p>Chilled Peach Halves Rice Krispies with Milk Creamed Ham and Chopped Boiled Eggs on Toast</p> <p>Roast Pork Candied Sweet Potatoes Buttered Asparagus Orange-Grapefruit Salad Bran Muffins Cherry Cobbler</p> <p>Spaghetti with American Meat Sauce Buttered Mixed Vegetables Fruit Salad — Honey Dressing Hot Buttered Crackers Baked Egg Custard Pudding Milk</p>	<p>23</p> <p>Broiled Half Grapefruit Egg Omelet Crisp Bacon Toasted Sweet Roll</p> <p>Salmon Loaf New Potatoes in Cream Sauce Green Beans Head Lettuce Salad Bran Muffins Cherry Cobbler — Cheese Milk</p> <p>Cream of Celery Soup Pimiento Cheese Sandwiches Assorted Crackers Congealed Waldorf Salad Fresh Strawberry Sundae Milk</p>
<p>24</p> <p>Grapefruit and Pineapple Juice Scrambled Eggs Ham Slice Buttered Hominy Grits Bran Muffins Milk</p> <p>Savory Beef Pie with Mixed Vegetables Spinach Salad with Hard Cooked Eggs and Crisp Bacon Corn Sticks Prune Cake</p> <p>Browned Luncheon Meat Slices Stuffed Baked Potato Buttered Summer Squash Pear Halves with Softened Cream Cheese Centers Fruit Sherbet Milk</p>		
<p>28</p> <p>Chilled Fruit Cocktail Hot Oatmeal Cooked in Milk French Toast Maple Syrup — Honey</p> <p>Oven Browned Chicken with Cream Gravy Fluffy Parsleyed Rice Mixed Buttered Vegetables Apple Muffins with Butter Citrus Fruit Cup — Cookies Milk</p> <p>Hot Vegetable Soup Buttered Toasted Crackers Assorted Fruit Plate Peanut Butter Muffin Boiled Grapenut and Egg Custard Milk</p>	<p>29</p> <p>Grapefruit Juice Cream of Wheat Cooked in Milk Soft-Boiled Egg Cinnamon Toast</p> <p>Liver Loaf-Vegetable Sauce New Potatoes and Green Peas Sliced Tomato Salad with Tarragon Dressing Grape and Pineapple Juice Assorted Cookies</p> <p>Boiled Ham Sandwiches Congealed Pear and Peach Salad Green Asparagus Tips in Cheese Sauce Blackberry Cobbler a la Mode Fruit Milk Shake</p>	<p>30</p> <p>Rice Chex with Strawberries and Cream Poached Egg — Canadian Bacon Dry Toast — Butter Milk</p> <p>Baked Chicken Supreme* Escalloped Potatoes Mixed Vegetables Tropical Fruit Salad Corn Muffins Angel Cake Wedges with Berry Whipped Cream</p> <p>Spanish Rice with Bacon Steamed Cabbage Wedges Harvard Beets Fruit Cup with Oatmeal Cookies Cold Chocolate Milk</p>
		<p>31</p>

Recipes for Sample Monthly Menus

400° BAKED CHICKEN

(Serves 25)

6 chickens (2½ to 3 lbs. each), cut up or individual pieces for 25 servings	½ cup milk
4 eggs beaten	1 lb. butter or margarine
	Seasoned flour (3 cups flour with 3 tbsps. salt)

Add milk to beaten eggs and dip chicken into it. Roll in seasoned flour. Melt butter in shallow baking pans and turn each piece over in butter, coating thoroughly. Arrange pieces of chicken in baking pans (skin side down). Bake at 400° F. for 15 to 20 minutes and turn pieces over with tongs. Continue baking for 30 to 40 minutes, until chicken is fork tender and golden brown.

WHIPPED EVAPORATED MILK TOPPING

For enough whipped topping for 5 pies: Place 2½ cups evaporated milk in a clean, dry freezing tray. Place in freezing compartment until mixture becomes mushy with ice crystals. Chill bowl and beaters in refrigerator while milk chills. Pour milk out into the cold bowl, do not dilute, and whip immediately and rapidly. Addition of 1½ tbsps. of lemon juice after the milk becomes stiff and continued beating will make it hold its stiffness better. Add ¾ to 1 cup sugar (vary to suit taste) after milk becomes stiff. Place on pies immediately before serving—not baked.

Evaporated milk will not turn to butter no matter how long beating is continued. If it fails to whip successfully, it needs to be colder. You can rechill and rewhip it without fear of its turning to butter.

Evaporated milk increases in volume about three times when whipped while whipping cream doubles in bulk when whipped.

BAKED CHICKEN SUPREME

Follow method for 400° Oven Baked Chicken. After 45 to 55 minutes total cooking time, for 25 servings blend 3 pints of cream of mushroom soup with 1 cup milk. Pour over chicken and bake 10 minutes longer.

CONEGELED STRAWBERRY PIE

(25 Servings)

Baked pastry for 5 nine-inch pies
5 qts. fresh berries plus 4 cups sugar
or
6 lbs. of frozen sweetened berries
1 lb. package strawberry gelatin
3½ cups boiling water

If fresh berries are used, wash, cap and crush berries. More or less than the four cups may be used, depending on tartness of berries. If frozen berries are used, partially thaw them and break into small chunks.

Dissolve strawberry gelatin in boiling water. Allow gelatin solution to cool and mix thoroughly with the crushed berries. Refrigerate. When the berry-gelatin mixture has almost congealed, pour into chilled baked pie shell and return to refrigerator until serving time. Serve with Whipped Topping if desired.

PENNY WISE MENUS

OVEN BAKED FRYER

Buttered Frozen Green Peas	Yellow Squash
Fresh Vegetable Salad	
Apple Muffins	Margarine
Boston Cream Pie	Milk - Coffee

RAISED PORK STEAKS

Buttered Frozen Purple Hull Peas	Buttered Cabbage
Green Onions - Radishes	
Corn Muffins	Margarine
Apple Flip Pie	Milk - Tea

BOSTON CREAM PIE

2 cups sifted cake flour	1 cup milk
1½ cups sugar	1 tsp. vanilla
2½ tbsps. baking powder	¼ tsp. almond extract (optional)
1 tsp. salt	1 egg, unbeaten
1/3 cup shortening	

Sift dry ingredients into mixing bowl. Add shortening, milk, vanilla, and almond extract. Beat 2 minutes (mixer at medium speed) or 300 strokes by hand. Add egg; beat 2 minutes as before. Pour into two greased 8" or 9" round layer pans. Bake in moderate oven (350°) 25 to 30 minutes. Makes 2 layers. Use one to make Boston Cream Pie; freeze the other or ice it and use following day. Split cooled cake layer in crosswise halves. Spread Custard Cream Filling over lower half. Cover with top half. Dust with confectioners sugar or spread with chocolate icing.

GOOD BUYS*

POULTRY — Fryers, roasting chickens.

PORK — Sausage, cured and fresh roasts, bacon.

BEEF — Ground meat, chuck roast, some steaks.

OTHERS — Eggs, sandwich meat, liver, franks; frozen and canned fish and seafood.

VEGETABLES — Irish and sweet potatoes, turnips and tops, spinach, collards, lettuce, cabbage, radishes, celery, onions, carrots; canned vegetables; dried peas, beans and rice.

FRUITS — Bananas, apples, oranges and grapefruits; raisins; frozen and canned fruits and juices.

* In plentiful supply and at prices attractive to food shoppers.

CUSTARD CREAM FILLING

1 cup milk, scalded	2 eggs, slightly beaten
½ cup sugar	1 tbsp. butter or margarine
3 tbsps. cornstarch	1 tsp. vanilla
1/8 tsp. salt	

Gradually add milk to mixture of sugar, cornstarch and salt. Cook slowly, stirring constantly, until mixture thickens (about 10 to 15 minutes). Add about ½ cup hot mixture to eggs and blend; carefully combine both mixtures and cook about 3 minutes, stirring constantly. Remove from heat; blend in butter and vanilla. Cool. Makes 1½ cups.

APPLE FLIP PIE

1 stick (½ cup) table fat	1 tbsp. granulated sugar
½ cup packed brown sugar	1 tsp. cinnamon
½ cup chopped pecans	Pie dough for 1 crust pie
1 lb., 4 oz. can sliced apples, drained	Dairy soured cream

Cream margarine and brown sugar together. Add nuts. Place in an 8-inch round cake pan. Spoon apples into pan. Combine granulated sugar and cinnamon and sprinkle over the apples. After pie dough for a 1 crust, 8 inch pie is prepared, roll it into an 8 inch circle. Place on top of apples. Bake in a hot oven (400°) about 35 minutes. Cool slightly. Invert on a serving platter while still warm. Serve with sour cream. Yield: 8 servings.

A Rehabilitation Nursing Record For Modern Times

By GEORGINA GREENE and LAVINA ROBINS

Times have changed and nursing has changed. Nurses and patients alike complain that the service given by nurses is less personal, less individual, less satisfying than that of many years ago. Nurses everywhere are writing and talking about the principles of patient-centered care. One mechanism that helps us in our efforts to apply such principles is an unusual record developed by the nurses in this hospital for the rehabilitation of the chronically ill.

In this hospital, the average patient is over 70 years of age and stays about 38 days. A recently immobilized fractured hip or a recent cerebrovascular accident is the primary problem of about 47 percent of the patients. Patients seldom enter with one simple medical problem; it has been said that each aging person becomes an accumulation of sequelae.

An important purpose here is to return each patient to maximum independence within his limitations. The minimal goal is self-care for patients. Because of their ages, few will return to employment.

Has Social Problems

Probably each older person enters any hospital with social problems as important as his medical problem. Aiding in the solution of these is as important as aiding in his physical and emotional rehabilitation.

Another purpose of this hospital is research: the inquiry into the process of aging; the exploration of the needs of the aging person who is ill; the analysis of the emotional and physical resources of the aging person who has a chronic illness; and the exploration of the significance of the older person's pattern of progress after illness or other stress. An additional purpose, which will not be discussed here, is education of the various professional persons in rehabilitation.

Routines can be deadly unless there is sharing of knowledge and feelings among the staff and patients.

This is especially true in a rehabilitation hospital. The older patient especially needs the security of routines, day-to-day continuity of purpose, and a uniform attitude among the staff. The older patient, perhaps more than any other, needs to be respected without being pushed beyond the limit of his endurance and needs to feel responsible for his own self.

THE AUTHORS

Miss Greene (Central Maine General Hospital School of Nursing, Lewiston, Me.; Ph.B., University of Vermont, Burlington, Vt.; M.S.N., Western Reserve University, Cleveland, Ohio) is nursing instructor at the Benjamin Rose Hospital, Cleveland, Ohio.

Miss Robins (B.S., University of Michigan) was director of nursing at the Benjamin Rose Hospital when this article was written and is now employed at the University of Minnesota Hospital, Minneapolis, Minn.

porting this progress.

A final purpose was to promote continuity of care between tours of duty and between individual nurses. Insofar as possible, we wanted the patient to receive the kind of care he would get if the same nurse were assigned to him every hour and every day.

The nursing record form is used on each hospital division, where there are two large Kardexes. Each Kardex holds a 5 by 8 inch visible index card for each patient, plus an 8½ by 11 inch nursing record for each patient. On these two cards we record almost any kind of information which may be needed. The 5 by 8 inch card is at the top and has lists of all current medications and treatments. A temporary check-off slip over its right side is replaced every 24 hours. The nurse checks off and signs for medications poured and given, so that she need not chart them. The charting is done by the secretary, who totals the daily dosage of drugs actually received by the patient and enters this total on the graphic sheet of the patient's chart.

More Productive Time

There is a similar system for recording treatments and laboratory work. Therefore, the nurse's charting time can be spent productively for the patient. Charting done by the nurse clarifies her knowledge of the patient's progress and produces a useful record for patient care and for research.

This special record form is a two-column, 8½ by 11 inch card, printed on a good grade of paper that will bear much use. The left-hand column (the functional level chart) is a check list of 10 activities of daily living, arranged in the order most useful for nurses on all tours (see illustration). After each activity, status grades are listed, with spaces for inserting check marks.

Besides a list of 10 activities, there is also a section marked "leg brace." Other aides to ambulation are listed under "ambulation," where they are most useful.

The status grades for several of the activities are as follows: zero or non-functioning, assist, observe, or independent. In general, these words have a literal meaning, but there is a

printed set of definitions to use.

It is important that all personnel understand all the terms. Therefore, each new nursing service employee is carefully oriented to the chart. Under several of the activities of daily living there are lists which can be checked either in the "Teach In" or "Do For" category, depending upon the goals set for the patient and his physical limitations.

Writes Nurses Notes

The nurse's notes are written in the right-hand column. This column remains in view in the Kardex at all times until the record form is transferred to the patient's chart, at the end of the patient's first three days in the hospital and at the end of each seven days thereafter. When removed from the Kardex, it is replaced by a new nursing record form. The head nurse, or the nurse assigned to the patient, records in the right column at any time any information not covered by the left column.

It is especially important that the nurse record objectively, that she know the difference between the facts concerning the patient's behavior and her own judgments. With the older patient, for example, it would be easy to record, "The patient is confused," or "The patient is uncooperative," which might or might not be accurate. If judgments are recorded, the nurse should also record the facts from which she made the judgments, so that other workers, including researchers, can make their own interpretations.

In this right-hand column, the nurse writes about the patient's adjustment to the hospital, his socialization with other patients, his moods, his habits that affect his living schedule in the hospital, his likes and dislikes, his reactions to family visits, his worries, and so forth. It is also important to record any "first" which is checked in the left-hand column—the first time a patient washes his own face, feeds himself, or walks to the dining room.

Using Check Marks

In order that the check marks can be changed from day to day as the patient's capabilities change, this left-hand column (the functional level chart) is furnished to the divisions as a separate half-page. This half-

page is placed over the full sheet in the Kardex and serves as a working sheet.

Appropriate check marks are made on it with lead pencil for the walking hours of the day and with red pencil for the normal sleeping hours. At the end of each tour, nursing personnel report any changes in activity to the charge nurse, who changes the check marks accordingly.

Then at the end of the patient's first three days of settling in the hospital, and at the end of each seven days thereafter, these check marks are transcribed permanently to the whole sheet, when it is taken from the Kardex and becomes a page in the patient's permanent chart folder. At the time when the nursing record is taken from the Kardex, the nurse writes in the right-hand column a summary of the week's achievement by the patient.

To prevent confusion and insure the writing of these summaries on

the correct dates, the ward secretary uses a system of dating. She lists summaries due on the division calendar and checks them off as they are recorded by nurses on each tour. The last to complete the summaries is the night nurse. When she has written hers, she removes the record from the Kardex.

The secretary inserts it in the chart the next morning, and the day nurse starts recording on the fresh form the secretary has inserted in the Kardex. Without the services of an alert, systematic secretary, the system would be much more difficult to maintain.

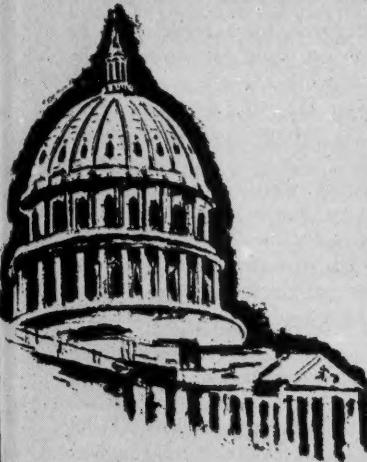
What it Shows

To illustrate the use of this record, we have included the story of William Davis, who was admitted from a general hospital where he had spent two weeks following a cerebrovascular accident.

What does his record tell about
(Continued on page 18)

ALVIN SHIRLEY CLEVELAND, OHIO		THE BENJAMIN ROSE HOSPITAL	
		NURSING RECORD	
		AIDS IN MANAGEMENT	
		Receptive-expressive aphasia. Upper, dexter - meals only. Lower, Hemiparesis.	
		EXERCISES QUAD SETTINGS	
		NURSING NOTES	
		DATE 9/31/59 THROUGH 9/31/59	
		9/28/59 1:30 pm Admitted per wheelchair, ✓ accompanied by wife. Wife works nights. ✓ will visit in mornings. Pt. is a heavy man, required 2 assistants to transfer on bed. Patient seemed unable to follow simple instructions and very fragile at talking-clusters at any time of day and does not stand upright. She asked to do so. Gave both hands and after wife left him here. Nurse unable to under- stand sounds made by patient; patient did not understand "Do you want a drink?" but reached out for glass when offered. Skin in good condition, no reddened areas. Both hand and foot swollen. Calf and arm seem spastic at times. Pt makes meaningful sounds seems to be in pain - relieved by 1/2 gr. of 3% Adm. Vital Signs: Temp. 97.2°, P. 72, R. 27, P. 70, regular, bounding; R. 22, morning. 9/28/59 (4-12 PM) Patient came at intervals during the evening. Required much urging and assistance to appear. Was fed in room in bed. At 7 PM, Pt. was found in elegance house after night walk. Signs recorded as absent. At 7 PM patient sleeping quietly. I. S. 200. 9/29/59 6 AM Has had a rather adult. Slept in short naps, awakened every 45 min. unable to recall where he was. Was awakened by looking about room hopefully, randomly, on bed sides, the front, other poster etc. Early AM was started at washing him for clothes. He stayed this place 3-4 min. and forgot to wash hands until asked to do so. See additional notes following page.	
		STAINS	
		NAME: DAVIS, Mr. William	
		ADDRESS: 40079	
		HOSPITAL NO.: Staff	
		DOCTOR:	
		AGE: 79	
		ROOM: 401	

CAPITOL



MINIMUM WAGES: Bill to raise \$1 hourly minimum wage gradually to \$1.25 and extend the law's coverage to 3,600,000 more workers — has been signed by the President and is now Public Law 87-30. All nursing homes are specifically exempt from coverage under this law.

MEDICAL CARE: H. R. 4222 by King (D-Calif.), would carry out the administration's plan for Medical Care for the Aged under Social Security. Referred to House Ways and Means Committee. A companion bill, S. 909, was introduced by Senator Anderson (D-N. Mex.) and was referred to the Finance Committee which will await House action.

SELF-EMPLOYED: The House Ways and Means Committee has approved H.R. 10 to permit the self-employed a tax deduction of 10% of their salary up to a limit of \$2,500 for their own private pension plan. The bill would apply to those (a) who have no more than 3 employees or (b) who have four or more employees for whom a pension plan has been set up by the employer.

SMALL BUSINESS: A Senate Banking Subcommittee held brief hearings on S. 836 by Proxmire to give the Small Business Administration authority to review all government procurement contracts. The bill also provides \$75 million more for small business loans.

SOCIAL SECURITY: The House has passed H. R. 6027 which would make 5 "improvements" in OASI benefits to be financed by an increase of 1/8 of 1% each in the social security taxes paid by both employers and employees. Benefits payable to an aged widow of a deceased worker would be increased from 75% of the worker's retirement benefits to 82½%. The insured-status requirement would be changed from one-quarter of covered work for each 3 calendar quarters to one quarter for each 4 calendar quarters. The bill would eliminate the requirement that a disability must be expected to result in death or to continue for a long and indefinite period in order for the disabled person to get benefits. The minimum benefit would be increased from \$33 to \$40. Men would be provided benefits at age 62, the same as now provided for women.

NEW DIRECTOR OF DIVISION OF HOUSING FOR ELDERLY Sidney Spector was sworn in as Director of the Division of Housing for the Elderly, Housing and Home Finance Agency. He will organize a new **OFFICE OF HOUSING FOR SENIOR CITIZENS** which will be headed by an Assistant Administrator of the HHFA. This office will coordinate the following three existing programs:

1. Assistance in the building of low-rent units through the Public Housing Administration.
2. Direct loans to builders of moderate-rent units.
3. Mortgage insurance provided by the Federal Housing Administration.

It will also serve as a focal point where information may be obtained about housing for the elderly.

NOTE: Mr. Spector was Staff Director of the Senate Subcommittee on Problems of the Aged and Aging.

ECHOES

(Continued from page 16)

him? He has right hemiparesis, receptive-expressive aphasia, and is 79 years old. If you were assigned to him for the day, you might learn from the functional level chart the following information.

He does not yet feed himself. He does not do his own hygiene activities, and you should make a special effort to teach him to wash his face, hands, and right arm. You will need to wash his left arm and under his right one, and, of course, any other parts he is not immediately able to learn to wash.

You will also see that Mr. Davis does not yet dress himself. In this hospital it is important that most patients get up and dress every day; so the articles of clothing that Mr. Davis is accustomed to wearing are listed in the "Teach In" section. As he learns to dress, the check marks will be erased. For at least a short time, Mr. Davis will probably be checked as "inconsistent" in dressing, since he will need help to learn to dress.

You can hope that he will progress to "observe," when he becomes physically able to dress but needs someone standing by to encourage him or see that he is able to perform the task. You hope that he will then become "independent," which means that he can dress himself without receiving assistance of any kind, either verbal or physical.

You will learn from the functional level chart that Mr. Davis is incontinent of stool and that he has a Foley catheter. With these facts in mind, you can realize that you must pay particular attention to Mr. Davis' timing of incontinence, so that bowel training can be instituted. The nurses aides have been taught to tell the nurse when and how often Mr. Davis is incontinent.

You will also know that it takes the assistance of two people to place Mr. Davis on the bed pan, that he does not yet have a brace, does not transfer in and out of bed, does not get about in a wheel chair; does not walk, and does not climb stairs. Even though he does not do these things, the fact that they are listed keeps you aware that you hope he will some

day do them again.

In addition, you may read in the nurses' notes that Mr. Davis is emotionally labile, that his wife works nights and visits him during the day, that he does not sleep well at night, and that he had a seizure within his first 24 hours in the hospital.

Armed with all this specific information plus the facts about treatments and medications from the other part of the Kardex, you can safely plan your care of Mr. Davis. Or you can supervise the care given by the nonprofessional personnel or assist a student in learning to plan and give his care. When you go off duty, you can report exactly what progress he has made and what activities need attention next.

From this exact information you will have many things — both major and minor — to tell Mrs. Davis when she asks how her husband is doing. You will have clarified in your own mind what questions you need to ask Mrs. Davis about her husband.

As Mr. Davis lives through the trying days of relearning how to be an adult human being in a social world, more and more of the check marks on his nursing record will be on the "independent" side of the record.

New aids to management may be added, such as an eating utensil designed for the left hand, or a brace for his right leg, or some other aid to ambulation. Always the nursing record will be both a true indicator of the patient's progress toward goals and a safe guide to the personnel.

There is an added advantage to this kind of record. It telescopes time and makes progress discernible, because it is recorded at weekly intervals. Where progress is as slow as it often is in geriatric rehabilitation, this factor can promote optimism as well as lend clarity to the record.

Broader Uses

At Benjamin Rose, the nursing record helps the nurse make her contribution when she works with other disciplines. The head nurse takes the Kardex with her to the biweekly rounds, where each patient is discussed thoroughly and new goals are set. The medical director, house officers, physical therapist, occupational therapist, social worker, and others,

including students and at times private doctors, attend these meetings.

The head nurse also takes the nursing record to weekly orthopedic rounds. Here members of the different professions watch the patient go through the prescribed activities in the physical therapy room and discuss in a practical way what the next steps shall be.

The nurse is able to compare the patient's performance here in the activities of daily living with his performance on the division. The orthopedist learns what the patient feels are his most important problems. Anyone who wishes, including the patient, may raise questions or contribute ideas. All keep in mind the eventual home-going of the patient.

Mr. Davis, for example, must be able to get about his apartment by himself while his wife is at work or sleeping. He will, therefore, begin physical therapy soon after admission.

First, he will learn to bring himself to a standing position in the safety of the parallel bars. Then he will walk between the bars. Then one day at rounds the group will feel that he is ready to try a four-legged cane.

In the meantime, the things that the head nurse learns about his experience in the parallel bars will be useful on the division in teaching Mr. Davis to transfer between a chair and his bed. Each new ambulation activity successfully tried in physical therapy will be followed through on the division more easily, because the head nurse notes changes on the nursing record when she is at rounds.

It is well to note here a difference between this hospital and most others. Certain risks must be taken here in order that the patient may learn by doing. If, for instance, a patient like our Mr. Davis is to learn to walk again, there is no way in this world for him to succeed unless he is allowed to try. Thus, there may be times when the patient's safety is not assured. However, he is safer in an environment where every worker knows exactly what the patient has been taught and what he accomplished yesterday. Also, every worker knows exactly what he is expected to do to help the patient without helping too much.

Avoiding Misuse

One of the hardest things for new staff members to acquire is the ability to allow the patient to do for himself. They have difficulty learning to interest the patient in doing, to encourage his clumsy attempts, and to bolster him through depressing days when progress is slow. To complicate the task, patients, especially those with a stroke, often lack motivation from within, especially at first. The borderline between *helping to learn* and *forcing to do* is shadowy, indeed.

In addition, there is another complicating factor—the similarity of the older patient to the very young one. Like a child with his mother, the older patient may make a contest of many situations if the nurse will let him. The nurse can fall into the trap by entering the contest. She tries then to get as many activities checked off as possible to win the game, while the patient also forgets his aims.

In this situation, the nursing record can become a detriment if not used thoughtfully. This risk exists especially with the nonprofessional workers. The record can become a score sheet for the activities the worker makes the patient do.

Therefore, it seems to be a function of the professional nurse to keep before the others at all times a clear concept of the aims for each patient. She helps give them perspective.

Also, the nurse must maintain the idea of the patient as a person, lest the functional level chart make workers regard him as a series of little jobs that must be done. It is easy for all to lose perspective at times.

The effectiveness of the tool also leads to another danger. It can dull personnel into unquestioning forgetfulness that they must always seek new uses for good tools and other ways to improve nursing care.

As an integral part of the communications system of this hospital, the record has proved to be an invaluable tool. Properly used, it can help the patient feel that even though he is not "taken care of" he is indeed "cared for." This need to feel cared for will become increasingly important as rehabilitation nursing becomes incorporated into all nursing.

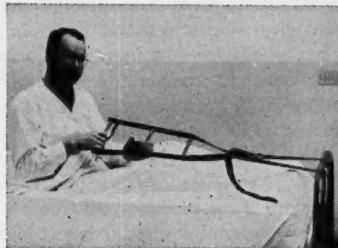
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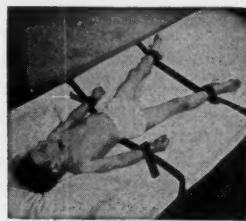
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Why a Registered Nurse Belongs In Nursing Home

By MARY E. PAVIOL, R.N.
Supt. of Nurses
The Dunn Rest Home, Inc.
Selma, Alabama

I have heard that it has been said that registered nurses are not necessary in a nursing home. That idea, to me, could hardly be more wrong. I have worked in a nursing home for four years, and never in my twenty years of active nursing—have I felt so necessary. Fortunately, the national nursing associations agree; however, many of the individual members of these associations do not share my feelings. After all, our work is to take care of the sick, and illness is certainly no respector of age. Sick people, regardless of age, require nursing care.

When I accepted my present position, I was told by several of my friends in the nursing field that I would find nursing home duty the most ungratifying work I could possibly do. Personally, I doubt if anyone in my chosen field could find his work more gratifying than I do. Where could I find so many people who could make me feel needed and loved so many times a day?

Nursing Care Needed

In a nursing home there are always some who are sick and partially disabled, and who certainly need skilled nursing care. Who is better able to give this care than a registered nurse? As most people are aware, elderly people, like children, appear to be quite well one minute and in the next may show symptoms of serious illness. A person trained to recognize changes in a patient's condition and who has been taught what to do in an emergency, would be better qualified to handle the situation until the doctor arrived. After all, a doctor is not always immediately available in a nursing home as is the case in a hospital where there are interns and residents. In a nursing

home, a doctor comes only for daily rounds or when he is needed. And, incidentally, a registered nurse would be the first to recognize that a doctor was needed.

Administer to Patient's Needs

Many residents of a nursing home are given medicines and treatments that require sterile technique. Would inadequately trained personnel be allowed to administer these in a hospital? Of course not . . . so, why should they be allowed to attempt to do so in a nursing home. In a nursing home, you not only administer to patient's physical needs, but a nurse has the real pleasure of making people happy in so many ways. By an act or word, it is so simple to brighten the patient's entire day. Frankly, it is just as easy by an unwise act or thoughtless word to make the patient very unhappy.

Personally, I can only speak for the Dunn Rest Home, when I say it is the happiest, brightest place one could wish to be in. The entire personnel, while on duty, seems to have one aim and that is to make the residents as comfortable, well entertained, and as happy as possible. There are a great many people in our area who help us accomplish this, such as the Red Cross Gray Ladies, churches of all denominations who have prayer service each week and church service on Sunday.

I could go on and on about the many reasons a registered nurse is needed in a nursing home, and also why I love my work. When I go off duty, I have a satisfied feeling of having done my best for a number of grand people. What nurse could ask for more than that?

Calendar of Events

June 14-15, 1961—Alabama Nursing Homes Association convention.

June 19-20, 1961 — Iowa Nursing Home Association Institute, Hotel Kirkwood, Des Moines, Iowa.

June 19-21, 1961 — University of Michigan, 14th Annual Conference on Aging. Theme: "A Study of the Political Aspects of Aging" — Ann Arbor, Michigan.

June 22-23, 1961 — Georgia Association of Nursing Homes and Homes for the Aged annual convention, Savannah, Georgia, DeSoto Hotel.

June 25-30, 1961 — American Medical Association convention. Theme: "Team-work in Medicine" — New York, N. Y.

July 5-8, 1961 — Fifth National and International Convention of Senior Citizens' Clubs, Broadview Hotel, Wichita, Kansas.

July 12-15, 1961 — Catholic Hospital Association convention — Detroit, Michigan.

Sept. 25-28, 1961 — American Hospital Association convention — Atlantic City, N. J.

Sept. 28-30, 1961 — National Nursing Home Institute convention — Pick-Carter Hotel, Cleveland, Ohio.

Oct., 2-6, 1961 — American Nursing Home Association annual convention — Pick-Carter Hotel, Cleveland, Ohio.

Oct., 16-17, 1961 — Licensed Nursing Home Association of New Jersey, Inc. Convention, Traymore Hotel, Atlantic City, N.J.

Oct., 24-25, 1961 — Iowa Nursing Home Association Convention, Hotel Kirkwood, Des Moines, Iowa.

Nov. 29-Dec. 2, 1961 — APWA's National Biennial Round Table Conference, Edgewater Beach Hotel, Chicago, Illinois.

The custom of kissing children good night is dying out. Parents nowadays can't wait up for them.

Nursing Home Administration Institute to be Held

The Maryland Nursing Home Association, Inc., in cooperation with the Maryland State Department of Health and the University of Maryland, cordially invites you . . . nursing home administrator or staff member . . . to further increase your professional knowledge and profit from the shared experiences of your professional colleagues at the Seventh Annual Nursing Home Administration Institute.

The Institute will be held on June 20, 21, 22, 1961, in the new air-conditioned Business and Public Administration Building at the University of Maryland, College Park, Maryland. Lodging and dining facilities will be available to the institute participants.

This year a refreshing new approach has been outlined to accommodate the specialized needs of nursing home administrators in their quest for more effective care of the infirm and the aged. Mrs. Edith B. Chance, Chairman of the Education Committee, American Nursing Home Association, will deliver the keynote address entitled "The Role of Nursing Homes in a Changing Society."

Ever conscious of the fact that all nursing homes have uniquely dif-

ferent needs and unsolved problems, the Institute this year will offer an opportunity for ALL to state these areas and solve them through the means of group discussions. Experi-

SEVENTH ANNUAL NURSING HOME ADMINISTRATION INSTITUTE

University College
University of Maryland
College Park, Maryland
June 20, 21, 22, 1961

enced group leaders and research persons, and outstanding speakers will be available to direct and stimulate each group discussion. We believe that a free and permissive interchange of ideas through voluntary group discussions will be creative, productive, and lend more meaningful insight to otherwise unsolved and seemingly unsolvable problems.

Please note that we have limited the number of participants to ninety. Therefore, we shall honor registrations in the order of their earliest mailing date. If registering for more than one person, please list additional names on a separate sheet.

To: The Director of Institutes

University College
University of Maryland
College Park, Maryland

Enclosed is a check or money order in the amount of \$ _____ for the Nursing Home Administration Institute Program. (Registration fee of \$15.00 per person will include instruction, program materials, and coffee breaks. Please make your check or money order payable to the University of Maryland).

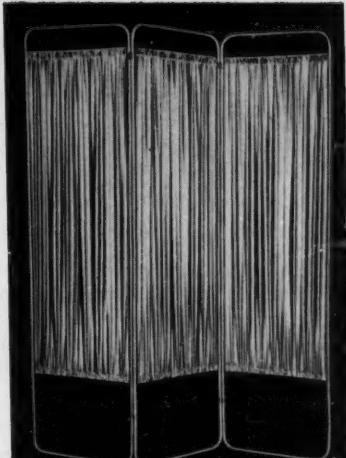
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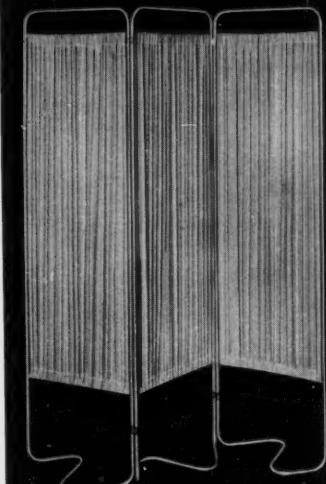
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New Program Planned For Nursing Home Journal

By WILLIAM E. BEAUMONT, JR.
Chairman, Journal Committee, A.N.H.A.

1. The Governing Council of the American Nursing Home Association, at its mid-year meeting, approved a program for Journal improvement. The improvement program is in five parts:

- I. Increased circulation.
- II. Increased paid advertising.
- III. Increased content.
- IV. Increased use for communications.
- V. Decreased costs.

Your help is needed, particularly on items I, III, and IV.

2. Members are requested to contribute articles, papers, news items, including photographs, charts, and graphs to "Nursing Homes," the official journal of the American Nursing Home Association for publication. These can be items specifically prepared for publication in the Journal or copies of speeches, research studies, or reports prepared for use on the State level. At all times proper credit will be given the author and your state.

3. Specific requests are made for articles on:

Nursing procedure
Fire safety
Business office procedures
Rehabilitation
Legal aspects
Special diets and menus
Nutrition
New home construction

4. The size of the Journal is being expanded. Last month the size increased by 4 pages and we hope it will continue to increase to 32 pages by the end of a year.

5. Because of the new Journal content, you will find that it will be increasingly useful to you and those persons interested in your nursing home, as well as a public relations

tool for reaching people in your community.

6. To help you and the new Journal put the nursing home story across, you are invited to subscribe to copies for interested parties, such as:

- a. Charge nurses
- b. Principal doctors
- c. Pharmacists
- d. Local newspapers
- e. Dieticians
- f. Physical therapists
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The Scoreboard...

SOLID LINE—1961 Membership
 DOTTED LINE—1960 Membership
 BROKEN LINE—1961 Quota

I. Twelve states have reached or exceeded their 1960 total memberships:

Florida	Montana
Iowa	Nebraska
Kansas	Nevada
Kentucky	New Mexico
Louisiana	Oklahoma
Mississippi	Virginia

II. Ten states have reached over 75% of their 1961 quota:

New Mexico	126%
Wyoming	100%
Kansas	89%
Oklahoma	88%
Rhode Island	85%
Nebraska	81%
Delaware	80%
Kentucky	80%
Florida	77%
Tennessee	75%

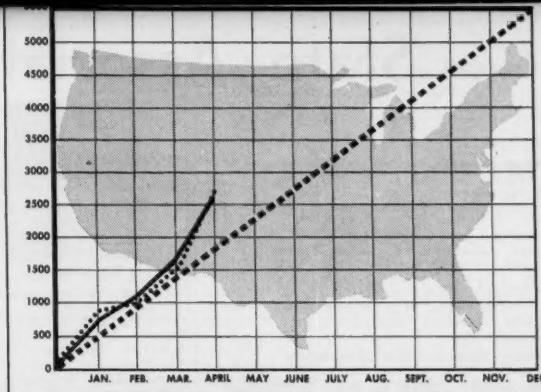
III. Thirty-two states have reached or exceeded 75% of their 1960 membership:

Arizona	Nebraska
Alabama	Nevada
Arkansas	New Hampshire
Delaware	New Mexico
Florida	North Carolina
Georgia	North Dakota
Illinois	Oklahoma
Iowa	Rhode Island
Kansas	South Carolina
Kentucky	South Dakota
Louisiana	Tennessee
Maryland	Texas
Michigan	Virginia
Mississippi	Washington
Missouri	Wisconsin
Montana	Wyoming

A regional break down on percentage of quota attained through April 30, 1961:

Region I	35%
Region II	19%
Region III	65%
Region IV	22%
Region V	46%
Region VI	69%
Region VII	54%
Region VIII	44%

As of May 4th, all states had submitted dues to the Executive Director.



	April 1960	April 1961	Total 1960	Quota 1961	% of Quota
ALABAMA	49	44	55	77	57%
ARIZONA	25	25	30	45	55%
ARKANSAS	20	30	39	54	55%
CALIFORNIA	394	246	592	624	39%
COLORADO	83	52	90	95	54%
CONNECTICUT	-0-	-0-	88	103	-0-
DELAWARE	14	13	14	17	80%
FLORIDA	75	97	87	125	77%
GEORGIA	57	62	73	100	62%
IDAHO	15	12	20	30	40%
ILLINOIS	150	147	183	250	58%
INDIANA	78	6	131	181	.03
IOWA	130	170	154	250	68%
KANSAS	42	58	52	65	89%
KENTUCKY	44	56	45	70	80%
LOUISIANA	17	26	17	-0-	not in
MAINE	30	23	40	60	38%
MARYLAND	64	55	69	100	55%
MASSACHUSETTS	151	117	284	400	29%
MICHIGAN	123	127	169	219	57%
MINNESOTA	49	-0-	109	300	-0-
MISSISSIPPI	17	22	17	50	44%
MISSOURI	53	110	124	175	62%
MONTANA	13	21	21	50	42%
NEBRASKA	-0-	81	73	100	81%
NEVADA	-0-	2	2	19	10%
NEW HAMPSHIRE	58	52	59	not in	not in
NEW JERSEY	23	39	84	165	23%
NEW MEXICO	13	19	15	15	126%
NEW YORK	68	66	175	210	31%
NORTH CAROLINA	55	57	68	100	57%
NORTH DAKOTA	13	11	14	15	73%
OHIO	47	26	72	122	21%
OKLAHOMA	47	88	65	100	88%
OREGON	29	14	34	44	31%
PENNSYLVANIA	77	81	110	200	40%
RHODE ISLAND	21	23	25	27	85%
SOUTH CAROLINA	16	18	21	25	72%
SOUTH DAKOTA	18	30	33	47	63%
TENNESSEE	113	99	119	131	75%
TEXAS	75	92	107	300	30%
UTAH	8	-0-	15	-0-	-0-
VERMONT	26	30	41	96	31%
VIRGINIA	25	48	44	90	53%
WASHINGTON	83	95	111	133	71%
WEST VIRGINIA	17	15	30	40	37%
WISCONSIN	98	93	122	150	62%
WYOMING	18	20	22	20	100%
TOTAL MEMBERS	2,641	2,618	3,964	5,589	46%

State Associations Directory

Alabama Nursing Homes Association

President: Garland L. Rollins, P.O. Box 305, Falkville, Secretary: Mrs. J. H. Kelly, P.O. Box 88, Haleyville, Treasurer: Robert V. Santini, Route 12, Box 158, Birmingham, A.N.H.A. Governing Council Member: Garland L. Rollins.

Arizona Association of Nursing Homes

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Arkansas Nursing Home Association

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California Association of Nursing Homes, Sanitariums, Rest Homes & Homes for the Aged, Inc.

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Colorado Nursing Home Association

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The Connecticut Chronic and Convalescent Hospital Association, Inc.

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Florida Nursing Home Association

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Massachusetts Federation of Nursing Homes

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If You Ask Me

QUESTIONS AND ANSWERS ABOUT NURSING HOMES

By BRUCE UNDERWOOD, M.D.



Q. I am planning to secure the services of a physical therapist and an occupational therapist on a consultation basis and would like to set up a small area with equipment. Would you suggest some of the most important items to purchase?

A. You should see the physical and occupational therapists whose services you plan to use and get their suggestions about the equipment that they will want. They will very likely want to know what kind of patients you have, how much space, and a number of other things about your home before deciding on the type of equipment needed. They may also be able to show you how to make some of the equipment inexpensively. Since individual therapists are usually quite adaptable as to equipment requirements, this should prove to be an easy problem to solve.

One thinks you should consider is a plan in which you or one of your staff could be made available to work with the therapists in carrying out the programs they will develop, if they desire such assistance. Also, it might prove very beneficial for you to provide an opportunity for the therapists to orient your staff to the things they will be doing with your patients, as this can be an essential element of the patients' ability to derive maximum benefit. It will be of considerable help too, if you and your staff can have an opportunity to hear what the therapists have to say about the concepts of self-care and restorative services. Utilizing these principles and skills, the staff of your home can save itself much effort and prevent many disabilities from occurring.

Q. What is your feeling regarding the funding of reserve accounts such as equipment depreciation accounts?

A. This question has long plagued business men. There are many "ifs" and "ands" involved in any answer to the question of funding.

Limited funding of equipment depreciation reserve accounts has one outstanding advantage, as does limited funding of building depreciation reserve accounts. Many service organizations such as hotels, hospitals, and nursing homes have found that funding these accounts to a level of about 50 percent of their total value is advantageous since it helps to insure that a fixed amount of capital is available at any time to handle unexpected building and equipment expenditures. Privately owned businesses have found such funding especially desirable since they cannot go to the community for donations to meet such unexpected costs.

Funding reserve accounts, however, has the great disadvantage of decreasing the amount of money available for daily operations and decreases the funds available as profit to the owners.

Before considering the funding of reserve accounts it is advisable to consult an accountant. He will be able to explain in detail how funding is accomplished and its effect on your home's particular financial operation.

It is generally believed that organizations showing cash surpluses after all expenses have been paid and a reasonable profit taken, should fund both their building and equipment reserve funds.

Q. From the statistics showing that the average nursing home patient is eighty years old and has multiple diagnoses of disabling character, isn't it somewhat unrealistic to talk about rehabilitation for these people?

A. I believe the answer to your question lies in the definition of rehabilitation. Many people think of it as referring particularly to regaining economic and social independence. In these terms, rehabilitation would be unrealistic for most nursing home patients. However, if we look at the definition now in

wide use, we find "Rehabilitation is the restoration of the individual to the greatest personal, social, and economic usefulness and independence of which he is capable."

The key here is "of which he is capable." Rehabilitation-oriented people feel that any increase in the level of self-care and independence is worth while for a number of reasons. Inability to take care of one's own daily needs is often a factor in depressed mental states and loss of self-esteem. Patients react in many ways to this, frequently becoming hostile, confused, frustrated, etc., complicating their care.

Promulgation of maximum attainable levels of self-care enables the patient to more adequately equate himself with his psychological need for self-respect, and to make a more satisfactory adjustment to his surroundings. Being more independent enables the patient to participate to a greater degree in the activities of the home, and in some cases, patients can learn to function well enough to carry on outside activities. Others can learn to care for their needs well enough to return to their own homes. In many cases, there is a growing philosophy that the nursing home is a natural step through which the patient passes on his way to recovery. Having started in the acute phase of a disease process in a hospital, progressed to a chronic disease hospital, then to the nursing home, then to his own home, such a patient is able to receive a type of care in each institution which meets his needs, but which involves costs that are appropriate to those needs. A nursing home that is able to offer care that is a continuation of care in preceding institutions may find itself in an advantageous position, because it is enabled to open its doors to a larger group of people, while creating a more hopeful atmosphere and improving patient attitudes. By putting effort into certain aspects of rehabilitation, much time can often be saved. For example, suppose one is able to teach an incontinent patient to control his bowels or bladder. Great savings and effort are possible in this area alone, not to mention the incalculable value to the patients, physical, mental and social well being.

Dr. Felix J. Underwood
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